

REQUEST FOR AMENDMENT TO PROTECTED HEALTH INFORMATION

Date: ____/____/____

Patient Name: _____

Date of Birth: ____/____/____

Address: _____

City/State/Zip: _____

I hereby request that Midwest ENT Specialists amend: (Specify type(s) of record(s) to be amended)

The following information is incorrect or incomplete:

Date(s) of information to be amended: (i.e., date of visit, treatment or other health care service)

Please state reason(s) supporting the requested amendment:

I understand that Midwest ENT Specialists may or may not fulfill my request for amendment. I understand that Midwest ENT Specialists is not able to alter original documentation for any reason. Whether my request for amendment is fulfilled or not, I understand this request will become part of my permanent Medical Record and included in any authorized requests for release of protected health information.

Signature of Patient or Authorized Representative

Date

Print Patient or Authorized Representative Name

Relationship to patient (if applicable)

Please submit this request to:

HIPAA Privacy Officer

Midwest Ear, Nose & Throat Specialists

215 Radio Drive, Suite 202, Woodbury, MN 55125

651.867.9006

Office Use Only

Received by: _____

Date Received: ____/____/____

Title: _____

☐ Response to request mailed to Patient/Authorized Representative

Date Mailed: ____/____/____